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MEDICAID COMMUNICATION NO. 04-01 **DATE:** January 26, 2004

TO: County Board of Social Services Directors
Institutional Services Section Supervisors
Statewide Eligibility Determination Agency

SUBJECT: "Answers to Commonly Asked Questions About Other Insurance "

The purpose of this communication is to advise the County Boards of Social Services, the Institutional Services Sections and the Statewide Eligibility Determination Agency of the issuance of a pamphlet entitled "Answers to Commonly Asked Questions About Other Insurance". The pamphlet provides answers to commonly asked questions about how NJ Medicaid and the Title XIX-funded portions of NJ FamilyCare work together with private health insurance to provide health coverage to applicants and beneficiaries.

The pamphlets are to be distributed to applicants for New Jersey Medicaid and NJ FamilyCare-Plan A services at the time of application, and to beneficiaries at the time of redetermination of eligibility. In addition, they should be made available in your agency's waiting room.

You will be receiving a supply of the pamphlets soon. When your supply has been depleted, reorder requests may be directed to the Division's General Services Section at (609) 588-2708.

We appreciate your assistance in conveying this information to applicants and beneficiaries. Your cooperation, as always, is very much appreciated.

Should you have any questions about this communication, please contact the Division's Bureau of Eligibility Policy field staff assigned to your county at (609) 588-2556.

Sincerely,

Ann Clemency Kohler
Director

c. Distribution

PeopleFIRST
NJ Department of Human Services

Answers to Commonly Asked Questions About Other Insurance

Some people who are enrolled in New Jersey Medicaid or NJ FamilyCare 'Plan A' also have or are covered by private health or other insurance. If this describes your situation, it is important for you to understand how these different types of coverage work together, and what your legal obligations are to the Medicaid or NJ FamilyCare program.

This brochure is intended to help explain your responsibilities to Medicaid or NJ FamilyCare if you have other insurance, and to answer questions about how to make the best use of all your coverage.

This brochure also will answer questions about what you should do if you receive a legal settlement or insurance claim as the result of an accident or injury caused by someone else.

Please take a few minutes to read it carefully.

1. What is New Jersey Medicaid and what is NJ FamilyCare?

New Jersey Medicaid and NJ FamilyCare are both health care programs paid for by federal and state funds. A person's eligibility for either of these programs is based on income and other information. Both programs pay certain medical and health care costs.

Both programs are administered by the New Jersey Division of Medical Assistance and Health Services (DMAHS). Neither Medicaid nor NJ FamilyCare should be confused with Medicare, which is administered by the federal government only.

In this brochure, both Medicaid and those NJ FamilyCare services paid for by Medicaid are referred to as "Medicaid."

2. What is private health insurance?

Private health insurance is any individual or group health insurance or health care plan that you pay for or that is provided through an employer, union, absent parent, or military or other organization. Like Medicaid, private health insurance pays all or part of the medical, vision, prescription, dental or other health care bills for you and/or your family.

Also, like Medicaid, private health insurance is often provided through an HMO.

3. Can I qualify for Medicaid if I have private health insurance?

Yes, you may qualify, regardless of other health insurance you may have.

In addition, if you do not have private health insurance but it is available to you, for example through an employer, Medicaid may require you to apply for it.

4. Why should I tell Medicaid if I have private health insurance?

Federal and state law require you to report your private health insurance coverage to your eligibility caseworker. In most cases, federal and state law also require you to use your private health insurance to pay for health care before using Medicaid.

5. What should I do to make sure that my private insurance and Medicaid work together?

Whenever you choose a health care provider, you should make sure that he or she accepts both your private health insurance and Medicaid. When you visit your health care provider, you should provide both your Medicaid identification card and your private health insurance information.

If the service you receive is covered by both your private health insurance and by Medicaid, Medicaid may pay a portion of the bill that is not paid by your private health insurance company. Generally, your health care provider must bill your private insurance company first. The provider may only bill Medicaid for any amount that is not paid by your private health insurance, and if Medicaid does pay anything, it will only pay up to a certain amount.

It is important to remember that if you receive services from a health care provider who does not accept Medicaid, Medicaid will not cover any portion of your bill.

6. What if I have co-pays or deductibles with my private health insurance?

If the co-payments or deductibles under your private health insurance plan are for services that are covered by Medicaid, the Medicaid program may pay some or all of them. Your health care provider must bill your private health insurance company first for the services he has provided. Then, Medicaid can be billed for the co-payment and/or deductible. Again, if Medicaid then pays anything, it will only pay up to a certain amount.

7. Will Medicaid ever pay the premiums for my private health insurance?

Premiums for a private health insurance plan are your responsibility. Sometimes however, Medicaid may decide that it is cost-effective to pay your premiums. An example might be if you have a medical condition that requires costly care that is covered by your private health insurance.

If you are eligible for, or are currently enrolled in, a job-related health plan, then you may be eligible for the Premium Support Program (PSP). If you or a member of your family have costly medical expenses and have access either to a job-related or individual insurance plan, then you may be eligible for the Payment of Premium (POP) program. If you are interested in learning more about either PSP or POP, contact the DMAHS Hotline at 1-800-356-1561.

8. What if my private health insurance changes?

You must report any changes in your health insurance coverage to your eligibility caseworker. This includes any changes in insurance companies or changes in what your insurance covers.

This requirement also applies to any health insurance carried by someone other than yourself who provides health insurance coverage for you and/or your family.

9. What if I am no longer covered by private health insurance?

If your private coverage stops, give your eligibility caseworker proof of termination. Proof may be:

- A letter from your health plan showing the date the coverage ended.
- A letter from your employer showing the date coverage was terminated.
- A signed affidavit.

10. What if I am injured by someone else and I receive a financial settlement?

If you are injured and there is a possibility that you may receive a financial settlement or a payment from someone else's insurance company as a result, you are responsible for providing this information to your eligibility caseworker. If you receive Medicaid through an HMO, you also are responsible for providing this information to the HMO.

If you receive a financial settlement or insurance payment as a result of an injury or accident, you are required to use this money to repay Medicaid for any related services that it has already covered. As a result of this settlement, you might also lose your Medicaid eligibility.

If you fail to repay Medicaid, or if you do not cooperate in establishing another person's or company's liability for your expenses, you can lose your Medicaid coverage and face both criminal and civil penalties.

11. What if my attorney or other legal representative plans to take legal action on my behalf, or actually gets a settlement or judgment for me?

You or your attorney or other legal representative are required by law to notify DMAHS's Bureau of Administrative Action and Recoveries (BAAR) in writing if a lawsuit or Worker's Compensation claim is filed on your behalf, and also when a settlement or recovery is received on your behalf. Both written notices must be sent to the Bureau of Administrative Action and Recoveries, P.O. Box 712, Unit 6, Trenton, NJ 08625.

You and your attorney or other legal representative are also responsible for making sure that any money received as the result of a legal action or Worker's Compensation claim is first used to immediately repay DMAHS for any Medicaid or NJ FamilyCare payments made in relation to the incidents that led to the legal action or claim. The remainder of the settlement can be paid to you only after these expenses have been reimbursed. Also, all settlements must be reported to the agency that determined your eligibility.

12. What if my attorney advises me to put my settlement into a Special Needs Trust?

If you receive a settlement of any kind, you must first use it to repay Medicaid for any bills it has paid for health care services related to your injury. Any money that remains can only be placed in a Special Needs Trust if you have the approval of the County Board of Social Services or of the Social Security Office, depending on which agency determines your eligibility for Medicaid.

13. A review: what are my responsibilities?

- To tell your eligibility caseworker if you have any type of insurance, and to report any changes in your private insurance to your caseworker;
- To make sure that your health care providers accept Medicaid as well as your private health insurance;
- To make sure that you show your health care providers both your private health insurance information and your current Medicaid Beneficiary ID card each time you receive medical treatment or other health care services;
- To tell your eligibility caseworker, and your Medicaid HMO, if you are enrolled in one, of any health care services you receive as the result of an accident or injury caused by someone else, including a motor vehicle accident;
- To report to your eligibility caseworker about any money that you receive as the result of an accident or injury, and to use any money you receive from a legal settlement or insurance claim as the result of an injury to repay Medicaid, if it has already paid for services related to the injury;
- To notify, or have your attorney or other legal representative notify, BAAR in writing if a lawsuit or other claim is filed on your behalf, and also when a settlement or recovery is received on your behalf. Both written notices must be mailed to the Bureau of Administrative Action and Recoveries, P.O. Box 712, Unit 6, Trenton, NJ 08625.
- To enroll in a group health insurance plan if Medicaid asks you to do so.

The New Jersey Medicaid and NJ FamilyCare programs help to protect your health and that of your family. As a beneficiary, you also are responsible for helping to protect these programs. By following the guidelines provided in this brochure, you will help make sure that both New Jersey Medicaid and NJ FamilyCare continue to be able to help you and your family stay healthy.

If you have additional questions about New Jersey Medicaid or NJ FamilyCare, please call 1-800-356-1561. If you call that number and have any questions about your health insurance, ask to speak with someone in the Bureau of Third Party Liability. If you have any questions about your insurance that covers accidents and injuries; auto, homeowners or workers compensation claims or lawsuits that you have filed; or Special Needs Trusts, ask for the Bureau of Administrative Action and Recoveries.